ALGER PEDIATRICS, P.C.

733 Alger SE Grand Rapids, MI 49507 | Phone: 616-243-9515 | Fax: 616-243-1815

Authorization for the use or disclosure of protected health information.

_____

Patient Name Date of Birth

_____

Patient Name Date of Birth

_____

Patient Name Date of Birth

☐ Transferring out of the office ☐ Personal copy of records

Protected health information to be disclosed:

____ Entire medical record

_____ Last well visit, immunization record, and problem list **only**

Method of records transfer:

☐ Encrypted electronic transfer ☐ Mail *(Please note that you may be charged the cost of postage if this cost exceeds $5.)*

*Please note that many records (such as well visit notes or immunization records) can also be accessed via the patient portal.

I request and authorize the disclosure or release of my records (protected health information) to the following:

Name: _____

Address: _____

City, State, Zip: _____

Fax Number: _____

Email address: _____

_____

Printed name Signature Date

Form revised January 2024